SKIN INFECTIONS, BACTERIAL

Level I

Skill Level: RN

Definition: Condition involving superficial layers of skin with or without pustules and minimal erythema. (e.g., cuts, scratches, mild impetigo, scrapes or insect bites).

MILD	
Subjective: • Complaint of localized pain, swelling and redness of short duration. Elicit: how, when, where, etc. 1. "I have a cut/scrape" 2. "I have an ingrown hair" 3. "I have a spider/bug bite" 4. "I have a boil"	**Assessment:** • Alteration in skin integrity • Potential for infection (or risk for infection)
Objective: • Skin lesion of 4 cm or less in size with superficial skin involvement. • Skin lesion of 2 cm or less involving the face. • Mild erythema and warmth surrounding lesion. • Pustules may or may not be present. • No swelling or fever, • There may be purulent drainage. • No red streaks from wound site.	**Plan:** **Optional self-care items patients can purchase from canteen:** • Antibiotic ointment • Dial Soap • Pain medications available on Units **At nursing discretion may use any of the below:** • Keep wound(s) clean and dry. • Warm compresses 3-4 times daily. Instruct patient to use a warm, moist towel or washcloth. Patient will need an additional towel to use for this purpose only. • Call Provider if patient is Diabetic or Immune Compromised. • Dressing as indicated to control drainage. • Return to clinic in 24-48 hours. If resolving, continue treatment x 24-48 hours. If not resolving see Level II. • Consider giving patient a supply of Betasept for skin washing. • Always check Tetanus status and provide Td booster, if >5 years since last vaccine. • If abscess is present refer to Level II. • Catheters or other devices related to infection should be removed if possible. (Contact medical provider for instructions.)

Nursing Education:

1. A conservative, mechanical approach is the treatment of choice for minor skin and soft tissue infections. This means that the lesion is relatively small, localized and there are no signs of systemic illness.

2. Frequently, incision and drainage of any fluid collections ("pus pocket", "boil") by a provider can provide relief without the use of oral antibiotics. Some advocate this approach alone for abscesses up to 5 cm in size.

3. See ODOC Document "Skin Infections in a Corrections Setting" for further information, especially regarding "Transmission and Prevention." Patients may need a single cell or special showering arrangements if drainage is difficult to control. Special care, including special showering arrangements, should not be done in an infirmary setting.

4. Staph Aureus, a common bacterial cause of skin infection, has developed resistance to many of the more commonly used antibiotics. To prevent new resistance, it is very important to use antibiotic therapy appropriately for serious infections only.

5. When measuring lesions, measure the area of swelling and induration. There may be a surrounding area of erythema as well, but this is not considered part of an infected "lesion."

Patient Education: See handout attached.

APPROVED:

______________________________ ______________
Medical Services Manager Date

______________________________ ______________
Chief Medical Officer Date

______________________________ 8/27/09
Medical Director Date

Effective Date: 8/09
Revised: August 2009

Patient Education—General Instructions for Skin Infections

The following instructions are for patients diagnosed with a skin infection.

Hand-washing and General Hygiene

- Regularly wash your hands with soap and water for at least fifteen seconds, especially:
  - Before and after touching a wound.
  - Before and after using the toilet.
  - Before eating.
- Shower frequently and put on clean clothes. Change clothing when it is soiled with wound drainage.
- Do not squeeze pimples or pus heads.
- If you have an open wound, especially if it's draining, it should be covered at all times with a bandage or bandaid.
- If your bandage comes off, dispose of it carefully in a leak-proof container as instructed by staff. Wash your hands. Inform a Correctional Officer that you need a new bandage if you don't have a spare.
- Keep nails trimmed short, and don't scratch.
- Don't share personal items such as razors, towels, wash cloths, bars of soap, etc.
- Don't allow other inmates to touch your wound.

Warm Compresses

- You may be instructed to apply warm compresses to your wound. Use a towel that you only use for this purpose. Get it wet with warm water. Apply to the wound three or four times daily. If your wound begins to drain, be sure to keep it covered at all times. You may need to contact Health Services for a bandage if the bandaids available on the units aren't large enough to cover and control your draining wound.

Antibiotic Therapy

- For severe infections, antibiotics may be prescribed. Take all prescribed medications exactly as instructed.

Report Any of the Following to Health Services

- Fever
- Red streaks that trail up from the wound.
- Increased wound drainage.
- Increased foul smell from the wound drainage.
- Enlarging or spreading infection.